Nondesignated Public Hospital
Supplemental Program
SFY 2007-08, Round 3
Contact Information

Hospital Legal Name	
Contact Person* **For negotiations**	
Title	
Mailing Address	
Telephone #	
Fax #	
Email Address	
Person Authorized to Sign Contract	
Mailing Address **(or indicate if same as above)**	
Emergency Room Status **(circle one)**	**standby / basic / comprehensive / closed / other (explain)**

***Contact person must have the authority to contractually bind the hospital to the negotiated terms.**

	Yes	**No**
Copy of License attached?		
Do you anticipate a change to your hospital's legal name or has the hospital's legal name been changed?*		
Do you anticipate a change in your hospital's ownership and/or operator, or has the hospital's ownership and/or operator changed?*		

***If yes, please provide all relevant information to your CMAC negotiator.**

Please return this form by November 30, 2007 to:

California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814
(916) 324-5597 fax
contact@cmac.ca.gov